**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

FUNCTIONAL PAIN CENTER
1401 E. RIDGE RD STE D
MC ALLEN, TX 78503

**Respondent Name**
PHARR SAN JUAN ALAMO ISD

**Carrier's Austin Representative Box**
Box Number 01

**MFDR Tracking Number**
M4-12-3475-01

**MFDR Date Received**
JULY 30, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Our claims have been incorrectly denied based on 'extent of injury'. Our claims used four diagnosis codes. Two of the codes are compensable; 842.0 & 840.9. The remaining codes 722.10 & 724.4 were found to be non-compensable. HealhSmart authorization listed the four diagnostic codes for our facility to proceed with services. HealthSmart first authorization letter was dated 4/6/11, and subsequent authorization letter again listing all codes as part of authorization for services was dated 4/19/11."

**Amount in Dispute:** $24,855.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The issue of the extent of claimant's injury was decided by Decision and Order sent out by the Division on 12/29/2011, as reflected in the provider's MDR request. The provider was a subclaimant at the contested case hearing that resulted in this Decision and Order and received a copy of the Decision and Order. The presumed date of receipt is 5 days after the date the Decision and Order was mailed, as provided by Rule 102.5(d). "

**Response Submitted by:** Parker & Associates, L.L.C., 7600 Chevy Chase Dr., Ste 350, Austin, TX 78752

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 4, 2011 to May 10, 2011 | 96150, 97799-CP-CA, 90899 | $24,855.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 05/23/11

- W12- Extent of Injury. Not finally adjudicated.
  Explanation of benefits dated 05/25/11
- W12- Extent of Injury. Not finally adjudicated.
  Explanation of benefits dated 07/01/11
- W12- Extent of Injury. Not finally adjudicated.
- W4- No additional reimbursement allowed after review of appeal/reconsideration.
  Explanation of benefits dated 06/30/11
- W12- Extent of Injury. Not finally adjudicated.
  Explanation of benefits dated 05/19/11
- W12- Extent of Injury. Not finally adjudicated.
  Explanation of benefits dated 06/27/11
- W12- Extent of Injury. Not finally adjudicated.
  Explanation of benefits dated 06/30/11
- W12- Extent of Injury. Not finally adjudicated.
- W4- No additional reimbursement allowed after review of appeal/reconsideration.
  Explanation of benefits dated 07/05/11
- W12- Extent of Injury. Not finally adjudicated.
- W4- No additional reimbursement allowed after review of appeal/reconsideration.
  Explanation of benefits dated 07/06/11
- W12- Extent of Injury. Not finally adjudicated.
- W4- No additional reimbursement allowed after review of appeal/reconsideration.
  Explanation of benefits dated 05/24/11
- W12- Extent of Injury. Not finally adjudicated.
  Explanation of benefits dated 07/11/11
- W12- Extent of Injury. Not finally adjudicated.

**Issue**

1. Did the requestor waive the right to medical fee dispute resolution?

**Findings**

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are April 4, 2011 to May 10, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 30, 2012. This date is later than one year after the date(s) of service in dispute. Furthermore, 28 Texas Administrative Code §133.307(c)(1) (B)(i) states: A request may be filed later than one year after the date(s) of service if: a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. Review of the requestor's submitted documentation finds that the disputed services involve issues identified in §133.307, subparagraph (B)(i). A contested case hearing was held on December 14, 2011 and the Decision and Order was signed by Hearing Officer on December 22, 2011. A copy of the Decision and Order was mailed out on December 29, 2011 to the requestor. Per 28 Texas Administrative Code §102.5 the Decision and Order is deemed received by the requestor on January 3, 2012. The requestor's dispute was received in MDR on July 30, 2012. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 11/20/2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.